Kenneth Young Center

Together We Thrive.

Kenneth Young Center – Consent to Services, Privacy, and Information Sharing For Mental Health and Substance Use Disorder (SUD) Services

Revised 1/26

Client Name: _____Date of Birth: _____

1. Purpose of This Consent

This consent allows Kenneth Young Center (KYC) to provide services and process healthcare claims. It explains:

- Your rights and responsibilities
- How your information may be used or disclosed under Illinois law, HIPAA, IMHDDCA, and 42 CFR Part 2 for SUD records
- How to file a privacy complaint

Reference: You have also received the KYC Rights & Responsibilities form.

2. Client Rights and Responsibilities

You have the right to receive care that respects your dignity, privacy, and legal rights. You are entitled to:

- Be treated with respect and have your privacy protected.
- Receive services without discrimination based on age, sex, race, ethnicity, religion, marital status, disability, sexual orientation, HIV status, military discharge, or ability to pay.
- Be free from abuse, neglect, exploitation, or harm. If you believe your rights have been violated, you may contact the Office of Inspector General at 1-800-368-1463.
- Participate in your care, understand your treatment, and be informed of risks, benefits, alternatives, and side effects.
- Review your records, request amendments, and request limits on disclosure.
- File a grievance or complaint without fear of retaliation and receive a timely response.
- Terminate services at any time.
- Have disabilities accommodated under the Americans with Disabilities Act (ADA), Section 504, and the Illinois Human Rights Act.
- Keep your HIV/AIDS and SUD records confidential, as protected under Illinois law and federal regulations (42 CFR Part 2).

Your responsibilities include:

- Providing accurate information about your health, past treatment, and medications.
- Informing KYC about legal involvement that may require records, reports, or testimony.
- Participating actively in treatment and asking questions if you do not understand.
- Treating staff, clients, and property respectfully.
- Supervising minor children if brought to the agency.
- Following program and safety rules, keeping appointments, and paying fees as required.

3. Receipt of Privacy Practices

You acknowledge that you have received and reviewed KYC's Notice of Privacy Practices, which describes your rights under:

- HIPAA (Health Insurance Portability and Accountability Act)
- Illinois Mental Health and Developmental Disabilities Confidentiality Act (IMHDDCA)
- 42 CFR Part 2 (for SUD records)

You understand you may revoke this consent in writing, except to the extent that action has already been taken.

4. Authorization to Use and Disclose Health Information

You authorize KYC to use and disclose your health information, including SUD and HIV/AIDS records, for the purposes of:

- Treatment, care coordination, or planning
- Payment or processing healthcare claims
- Healthcare operations (e.g., audits, quality assurance, staff training)

Information may include:

- Assessment records (psychiatric, mental health, educational, vocational, SUD)
- Treatment plans (psychiatric, medical history, SUD, individualized treatment plans)
- Other information (admission/discharge summaries, progress notes, legal records, medication records)

Sensitive information categories include:

- HIV/AIDS
- Alcohol/Substance Use

You understand that if the entity receiving your information is not HIPAA-covered, your records may be redisclosed and no longer protected by HIPAA. SUD records remain protected under 42 CFR Part 2.

5. SUD Records (42 CFR Part 2)

If you receive SUD services, your records are federally protected.

- KYC may share these records only with treating providers, payors, or staff assisting with your care.
- Disclosures require your written consent.
- Uses for civil, criminal, administrative, or legislative proceedings against you are strictly prohibited.
- You may revoke consent in writing, but it will not affect prior disclosures made under this authorization.
- Note: If receiving SUD services, additional consent forms may be required for:

- SUD Counseling Notes
- Use of records in civil, criminal, administrative, or legislative proceedings

6. Consumer Choice – DHS Funded Services

If the Illinois Department of Human Services (DHS) pays for your services, KYC must report demographic and service information.

☐ I choose to have KYC bill DHS/insurance and understand my information will be reported.
☐ I do not choose to have KYC bill DHS/insurance and understand I will pay the full fee.

7. Communication Authorization

KYC may communicate with you by phone, text, or email.

- These methods are not always secure; others may intercept messages (e.g., household members, employers, or internet providers).
- Communication will be limited to non-clinical matters such as appointments or billing.

For urgent clinical needs, call the crisis line at 1-847-524-8800, press 7, or go to the nearest emergency room.

☐ Phone ☐ Text ☐ Email

8. Minors Aged 12–17

- Minors 12–17 may consent on their own to outpatient mental health or SUD services.
- Parent/guardian signatures are required only for:
  - financial responsibility (billing/insurance), or
  - treatment decisions when deemed clinically necessary by the provider.
- Parent/guardian does not automatically receive access to psychotherapy notes or sensitive records unless the minor consents.

9. How to File a Complaint

You may file a complaint with:

- KYC Privacy Official: (847) 524-8800
- U.S. Department of Health & Human Services (HHS/OCR): 1-800-368-1019 | www.hhs.gov/ocr

You may also contact:

- Guardianship and Advocacy Commission: (866) 274-8023 | www.gac.state.il.us
- Equip for Equality: (800) 537-2632 | www.equipforequality.org
- Illinois Department of Human Services – Division of Behavioral Health & Recovery: (800) 843-6154 | www.dhs.state.il.us
- Illinois Department of Human Services – Division of Behavioral Health and Recovery (DBHR): (800) 843-6154 | DHS.DBHR.SUDHelp@Illinois.gov
- The Joint Commission: (630) 792-5000 | www.jointcommission.org

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10. Acknowledgment and Signatures

By signing below, you acknowledge that you:

- Have read and understand this consent
- Have received a copy for your records
- Consent to treatment and authorize use/disclosure of your health information as described

Client Signature (Required for minors 12-17 in addition to parent/guardian):

_____ (Print): _____ (Signature) Date: _____ / _____ / _____

Parent, Authorized Representative, Legal Guardian Signature (if applicable):

_____ (Print): _____ (Signature) Date: _____ / _____ / _____

Witness Signature:

_____ (Print): _____ (Signature) Date: _____ / _____ / _____